Massachusetts Priority Needs
Past (FY07) and Current (FY08) Activities, and Plans for FY09

Massachusetts established its Priority Needs as a result of the Five-Year Needs Assessment in 2005. The following activities address Massachusetts Priority Needs. They are in addition to activities listed under National or State Performance Measures (reported elsewhere). Many of the state's activities address both a Priority Need and a National or State Performance Measure. Generally, activities reported in the Block Grant Annual Report under the relevant performance measure narratives are NOT repeated here. Instead, cross-references to measures are provided for each priority.

FY07 Accomplishments are reported for the Bureau of Family and Community Health (BFCH). During FY08, reorganization within the Department of Public Health shifted responsibilities with Title V located in the Bureau of Family Health and Nutrition (BFHN). The BFCH existed in FY07; the BFHN in FY08 and FY09.

"Current Activities (FY08)" and "Planned for the Coming Year (FY09)" sections focus primarily on new activities for FY08 or FY09 versus activities continuing from earlier years.

Priority Need # 1: Improve the health and well-being of women in their childbearing years.

Many of the accomplishments and activities for this priority are described under the following National or State Performance Measures: NPMs #8, 11, 15, 17, and 18 and SPMs #1, 2, 3, 6, 9, and 10. Also reference State Priorities #2, 6, 7, 8, 9, and 10.

Additional Past Accomplishments (FY07):

In FY07, BFCH formed a working group to coordinate efforts around gestational diabetes. Although focused on gestational diabetes, the group highlighted and also focused activities to have OB providers link women with gestational diabetes (and pass information) to primary care in the postpartum period to ensure that women receive on-going preventive health care to address their increased risk for developing diabetes. BFCH activities included:

--Diabetes Prevention and Control Program: Developed systems for management of Type 2 diabetes in accordance with guidelines. Worked with a multi-disciplinary task force to develop and implement gestational diabetes management guidelines and standards of care; develop consumer education materials to support guidelines both during pregnancy and ongoing for preventative care after delivery. Participated in Massachusetts Diabetes Coalition.

--Center Care: Provided ongoing health education including information about chronic disease to women accessing prenatal and postpartum care, and linkage of women to appropriate services for themselves and their families.

--WIC: Trained nutrition staff on GDM, assessed clients for GD or history and provided individualized plan, coordinated with medical and other providers, provided nutritional counseling for postpartum women to prevent future diabetes risk. Nutrition staff focused women on maintaining a healthy weight through pregnancy and achieving a healthy postpartum weight, emphasizing the lifelong benefits for women and their families. WIC programs corresponding to the 32 community health centers that receive Community-Based Services for Women of Reproductive Age contracts were required to have nutrition coordination agreements with these health centers detailing how participants receive comprehensive coordinated health and nutrition services, including high risk follow-up for GDM.

--ODADS (now ODT): Included questions regarding pre-pregnancy diabetes and gestational diabetes on PRAMS and began to link data sets (including births and WIC) in PELL to provide information.

--DPECSHN: EIPP home visitors provided education and monitoring for women with GD during pregnancy and postpartum. Health education highlighted the issue of attaining and maintaining a healthy weight to benefit both postpartum women and infants.

Women who access family planning services are provided preconception and interconception counseling as well as pap and other screening, and are linked with primary care services, health insurance, and other services to promote their overall health and well-being in their childbearing years.

In collaboration with 18 statewide perinatal advocacy and support agencies, including breastfeeding support organizations, MDPH implemented the 18th annual "Partners in Perinatal Health Conference," which provided up-to-date training and multidisciplinary networking opportunities to over 500 perinatal care providers across the Commonwealth. The conference is an opportunity to highlight the need for improved preconceptional and interconceptional care. All conference participants received educational materials about the World Health Organization Breastfeeding Code. Special workshops focused on: the postpartum period, the Black Women's Health Study, human milk banking, contraception education, hormones of labor, moving from data to action, communicating and caregiving across boundaries," body work and belly dance for pregnancy and beyond, emotional impact of prematurity on families, the precocious puberty "epidemic," and media's impact on women's health and childbirth." This collaboration is affiliated with the state Healthy Mothers, Healthy Babies Coalition.

Ongoing, the Division of Health Promotion and Disease Prevention (DHPDP) in the BFCH (and now in BCHAP) seeks to influence social norms that provide a framework for health promotion and disease prevention across life stages, including for women of reproductive age. Its key target populations are ones that experience disparate health outcomes including women who are under or uninsured, have low incomes, have disabilities, are African American or Hispanic, or have low literacy. DHPDP collaborates with a range of public and private agencies and institutions representative of the social determinants of health to foster development and implementation of policy and environmental changes in multiple venues that enable healthy individual behaviors. Collaborations include state coalitions focused on the promotion of healthy weight and addressing specific diseases including asthma, cancer, diabetes, heart disease and stroke. DHPDP maintains wellness, preventive health care, and chronic disease surveillance in collaboration with other DPH bureaus (e.g., for the BFRSS) and state agencies (e.g., for hospitalizations).

As presented in detail in relation to other measures and priorities cross-referenced above, additional BFCH efforts focused on healthy weight, breastfeeding, smoking cessation, violence, injury, mental health, and multiple aspects of women's health through the lifespan.

A Helping Hand: Mother to Mother (AHH) project began enhanced identification of and services for substance exposed newborns (SENs), their mothers and families. The first pilot site, Cambridge-Somerville, enrolled seven families. The project's peer Family Support Specialist--herself a woman in recovery--mentored, supported, and advocated for the mothers to obtain substance abuse services and stay in recovery, and for their SENs to obtain appropriate developmental services.

EIPP Nurses, Social Workers, and Community Health Workers developed formal linkages with medical providers and birthing hospitals, ensuring continuity of care. EIPP provided comprehensive health assessments to 570 pregnant and postpartum women on intake, with linkages to primary and specialty health care providers and referrals to community based services.

The Bureau of Substance Abuse Services provided substantial programming for women of childbearing age to address drug and alcohol use. Enhanced program models were been developed specifically for women and for families.

As part of an effort to better understand the causes of pregnancy-associated mortality, the Maternal Mortality and Morbidity Review Committee (MMMRC) committee at DPH used the PELL data to investigate four maternal deaths due to complications of chorioamnionitis, which is an infection of the chorion, amnion and amniotic fluid. This analysis has immediate clinical applicability in providing physicians with new information on which to realistically counsel women with chorioamnionitis who are 17-25 weeks gestation about the increased risks for fetal loss, neonatal death and maternal health risks including maternal death from chorioamnionitis. This analysis was presented at the Maternal and Child Health epidemiology conference in December 2007.

Additional Current Activities (FY08):

In collaboration with 18 statewide perinatal advocacy and support agencies, including breastfeeding support organizations, MDPH implemented the 19th annual "Partners in Perinatal Health Conference," which provided up-to-date training and multidisciplinary networking opportunities to over 500 perinatal care providers across the Commonwealth. The conference is an opportunity to highlight the need for improved preconceptional and interconceptional care. All conference participants received educational materials about the World Health Organization Breastfeeding Code. Special workshops focused on: the rising C-section rate, using banked human milk, using ceremony and ritual with new parents, nurses and doulas working together to support birthing mothers, nutritional strategies re obesity and pregnancy, portrayal of birth in the media, impact of trauma history on new mothers, supportive labor environments, cosmetics safety, community-based lactation support, gestational diabetes, grief strategies for infant death. This collaboration is affiliated with the state Healthy Mothers, Healthy Babies Coalition.

EIPP negotiated with 3 of 4 Massachusetts Managed Care Organizations (MCOs) to provide reimbursement for home visits and groups. MCOs have identified CPT codes and reimbursement rates for home visiting services to improve the health and well-being of pregnant and post partum women and their infants.

A Title V Region 1 MCHB conference was held at Boston University in the fall of 2008 with national experts on the lifecourse perspective to further develop state understanding, coordination, and plans. Discussion continues of ways to incorporate this perspective into the MCH needs assessment.

The DPH Gestational Diabetes Workgroup is collaborating with ASTHO to implement a Gestational Diabetes Project that aims to advance the integration of chronic disease and maternal and child health to prevent and manage GDM. ASTHO provided technical assistance to convene a one-day workshop (October 2007) for key Massachusetts stakeholders as a first step in developing a state strategy to address GDM in women of reproductive age. Presentations included new GDM analyses from the PELL data system. PELL demonstrated 25% higher rates of gestational and other diabetes than the birth certificate alone. Tasks include improving DPH capacity to track GDM and diabetes mellitus on a population basis. PELL's longitudinal capacity to examine sequential deliveries will provide the means for a CDC-led analysis of conversion of gestational to chronic diabetes across pregnancies. Along with PELL, PRAMS will be part of the ongoing efforts to improve surveillance on this topic. Three workgroups were established to follow up recommendations from the conference: (1) communications—increasing patient and provider awareness of GDM diagnosis, management, and prevention of type II diabetes; (2) continuity of care—improving continuity of preconception, prenatal and postpartum care, and (3) surveillance—enhancing surveillance for women with GDM and their children. Recommendations for strengthening the MA healthcare system response to GDM and diabetes prevention will be developed from these workgroups.

At an April meeting with the MA Medical Society, the DPH Medical Director presented updated clinical advisory guidelines for routine testing for HIV in pregnant women, developed by MassCARE and the HIV/AIDS Bureau. A mailing to women's health providers (OB/GYNs, Family Practitioners, Nurse Midwives) and pediatricians is in process.

Using the Pregnancy to Early Life Longitudinal (PELL) data system, Gene Declerq of Boston University continued to take the lead in collaboration with the BFCH, to study maternal outcomes (increased morbidities) for repeat cesareans with no indicated risk and published the study "Maternal outcomes associated with planned primary cesareans compared to planned vaginal births" in *Obstetrics and Gynecology*. The MCHB also awarded funds to study increasing disparities in c-section use and associated outcomes. The results from this study are informing new efforts of the DPH Medical Director to address Massachusetts rising c-section rate (currently over 30%). PELL data was also utilized in part by Mary Barger (Maternal Mortality Committee, informed by the chorio study) to refine the scientific basis for the risk factors for uterine rupture, the principle rational for the efforts to limit VBACs, contributing to increasing c-sections. A manuscript concerning maternal and perinatal outcomes of mid-trimester chorioamnionitis was prepared and submitted to MMWR for review. Other PELL analyses related to health of women of reproductive age and maternal health continue and a manuscript concerning the effect of late preterm birth and maternal medical conditions on newborn morbidity risk was published in *Pediatrics*.

BSAS continues to develop and strengthen treatment services for women and children. The Bureau funds substance abuse treatment and support for homeless families and those at risk for losing custody of their children in eight family treatment programs, three family transitional programs, and a number of permanent housing scattered sites for families. The Bureau continues to work with families in shelters by providing intensive case management as well as information and education to both the staff and guests at the shelters.

BSAS partnered with DPH Bureau of Primary Healthcare to fund 32 Community Health Centers to provide alcohol and other drug screening, brief intervention, and referral to treatment (SBIRT) for women of childbearing age and adolescents. The Bureau trained the staff at the Health Centers in using screening tools, providing brief interventions for those that were found to be positive, and in referring patients that needed treatment. The screening tool also screened for tobacco, domestic violence, and depression.

The BSAS, in collaboration with the Department of Social Services (DSS), applied for and received federal funding to work with Western MA families, in their homes, who are at risk of losing custody of their children. The Family Recovery Project is a partnership between the BSAS, DSS, Institute for Health and Recovery (IHR), and over twenty social service agencies in Western MA to coordinate services for families with a history of substance abuse and mental health issues.

BSAS funded a pregnant women's services coordinator at IHR to ensure that pregnant women seeking services have access in a timely manner. BSAS has also convened a group of experts in providing detox to pregnant women to review the current protocols and to work on reducing barriers to treatment.

BSAS helped to develop Women's Treatment Standards guidance for all the states. These standards are in the process of being finalized and adopted by the National Association of State Alcohol and Drug Abuse Directors (NASADAD). The Bureau has begun to review and revise its treatment standards for pregnant/postpartum women, families, and women in treatment and will draw from the NASADAD document for guidance.

PELL worked actively with BSAS this past year to develop an NIAAA R21 proposal, entitled "Linking State Data to Identify/Address Alcohol Abuse in Women of Reproductive Age". This proposal will allow BSAS to improve its needs assessment capability among women of reproductive age, pregnant women, and mothers of young children, as well as to assess the availability and efficacy of its alcohol treatment services. This innovative collaboration is to create a unique MA MCH data system linking the PELL data and the BSAS participation and treatment data to create complete reproductive, medical and substance treatment histories for women of reproductive age. The preliminary work within the PELL Data System alone revealed a much larger number of women utilizing hospital based services with alcohol or drug diagnoses than known to BSAS.

The AHH program's second pilot site began providing services in the fall. During the first year of operation (February 2007-2008) in one pilot site 13 mothers were served.

Additional Activities Planned for the Coming Year (FY09):
Continue collaboration with statewide perinatal advocacy and support agencies to implement the 20th Annual Partners in Perinatal Health Conference in May 2009.

Continue GDM Workgroup activities. With leadership from CDC, ODT will continue PELL diabetes analyses and begin to analyze GDM data available through PRAMS.

BSAS is planning an FASD conference in FY09 for state agencies, providers, and consumers that will focus on both children and adults with FASD - how to prevent, recognize, diagnose, and adjust treatment practices for those with FASD.

BSAS will be implementing modality management meetings for all women's residential treatment programs.

The PELL team plans to submit additional grant proposals to NIDA to combine the BSAS- PELL data sets to explore the same themes as noted above among women with drug related problems and to NIAAA.

The PELL team also plans to submit an R01 grant proposal from the Massachusetts Outcomes Study of Assisted Reproductive Technology (MOSART) Collaborative (DPH/BU/CDC) to enhance understanding of the longitudinal sequelae of ART on women as well as infants.

Priority Need #2: Improve adolescent health through coordinated youth development and risk reduction.

See also accomplishments and activities related to this priority described under the following National or State Performance Measures: NPMs #6, 8, and 16, SPM #2, 4, 6 and 10. Also reference State Priorities #4, 6, 7, 9 and 10.

Additional Past Accomplishments (FY07):
Current cigarette use among high school students decreased from a peak of 35.7% in 1995 to 17.7% in 2007. Sales of tobacco products to minors fell from 22.7% in FY 06 to 10.3% in FY 07. This drop coincided with a significant increase in funding to local programs to conduct regular tobacco retailer education and random compliance checks and the "Under 27" campaign in FY 07 to build awareness about tobacco sales laws and helped retailers train employees to check for proper ID. The percentage of adults who reported voluntary "no smoking in the home" rules nearly doubled between 1993 and 2006 (BRFSS).

MTCP increased prevention programs for young people. MTCP formed Mass Youth Against Tobacco (MYAT) to more cost-effectively oversee prevention efforts. MYAT awarded 45 minigrants to youth groups across Massachusetts and drew 160 participants in a statewide film shorts competition. The winning video was shown for a month on a major network, which donated spots; runner-ups were shown during movie previews and all qualifying applicants posted on the web. MTCP youth efforts also included a youth summit, attended by over 100 youth although rescheduled after a snowstorm, and a statewide youth advisory council. Youth advised the Commonwealth in development of a targeted website: www.the84.org which refers to the 84% of 7th-12th grade students who did not smoke cigarettes.

BSAS and MTCP developed a booklet, "Talking to your pre-teen about alcohol, tobacco, and other drugs: A 10-step guide for parents."

During the school year, school nurses in ESHS districts provided more than 5.3 million encounters to students of all ages, many of whom were adolescents. School nurses in 87 ESHS districts reported a total of 2,393 assessments of students for suspected substances.

In addition to school nurse tobacco prevention and cessation services described in SPM#2, a major randomized controlled trial began regarding school nurse interventions for tobacco cessation:

- During the 2002-03 school year, the SHU collaborated with the University of Massachusetts, Department of Preventive and Behavioral Medicine, in conducting a randomized controlled trial (RCT) to determine if school-nurse interventions could help individual students stop using tobacco. The 71-school study demonstrated the feasibility and potential efficacy of this intervention in increasing self-reported short term (6 week and 3 month) quit rates among adolescent smokers who wished to quit.
- Based on these outcomes, the National Institutes of Health (NIH) has awarded the University of Massachusetts Medical School (UMMS) a 4-year grant to test this intervention in a randomized controlled trial, designed to be delivered by the school nurse in the course of her/his routine clinical duties through four individual 15 to 20 minute sessions with individual teens. As a result of the partnership of UMMS and the SHU, 36 public high schools with an enrollment of at least 350 students are currently participating in this NIH grant study. The training for this individual intervention has been temporarily stopped in order to prevent influencing the results of the study; this may have influenced the numbers of students receiving individual counseling.

Science-based pregnancy prevention programs engage in youth development activities and work to address substance use and pressures and other risk factors.

ODADS (now ODT) coordinated the revision of *A Shared Vision for Massachusetts Youth and Young Adults*. This document, a collaborative effort of the Department of Public Health and the Governor's Council on Adolescent Health, provides a broad, descriptive view of the health status of youth and young adults in Massachusetts by coordinating and summarizing data on youth development in relation to five key strategic goals. The data are derived from a number of different data sources from multiple state agencies.

Training was provided to all SBHC staff on motivational interviewing to increase their level of skill in interviewing adolescents and obtaining information about their risk and protective factors. The SBHC Risk and Resiliency Assessment tool was redesigned to include "Family Relationships" (a well-documented protective factor). The SBHC program is assessing "School Connectedness," Community Service, Truancy and School Failure in "Academics" section of the tool. Clinicians have been trained on the importance of protective factors to counterbalance risk.

SBHC standards require that all students receive an annual comprehensive risk and resiliency assessment. The Critical Health Behaviors are consistent with those identified by the Healthy People 2010 objectives and the initiatives of the CDC DASH program. Ongoing site visits and clinical chart reviews are conducted to assess the documentation of screening activities and risk-reduction strategies when problems are identified.

Glynis Shea of the Konopka Institute conducted a training with DPH and other state agency staff on "Framing and Building Public Will for Youth" to improve how adolescent health issues are communicated.

Additional Current Activities (FY08):
Youth smoking prevention activities continued. The www.the84.org youth smoking prevention website launched in August. "The84.org" message and brand was promoted through FaceBook and other social networking websites. MYAT has expanded in FY08 to include 57 statewide grantees. Youth regional advisory groups now collaborate with regional centers for healthy communities to provide assistance to mini-grantees and coordinate activities.

The Nutrition and Physical Activity Unit (NPAU) partnered with the MCTP to implement a pilot program expanding the use of the 5-2-1 healthy weight message by added "0" (no tobacco) in 10 middle schools that had previously been funded to implement Healthy Choices.

The 2007 Youth Summit hosted over 500 youth. Teams of youth and adult allies representing schools, faith-based organizations, after-school programs, healthcare facilities, outreach programs and other youth-serving organizations, came together for a full-day of networking, celebration, resource-gathering, skill-building and action planning. Youth and adult presenters from a variety of youth programs conducted morning workshops highlighting their efforts to impact different public health issues. Workshops celebrated the successes of programs and expanded the definition of youth development, inspiring participants to replicate effective strategies in their own communities. Presenters worked with participants in strategy sessions, sharing information, skills and local resources in order to layout the initial planning steps for implementing similar initiatives. There were community networking opportunities throughout the day, as well as informational resource tables highlighting effective, research-based initiatives.

An update of *A Shared Vision* was provided to the Governor's Adolescent Health Council. They began discussion of adolescent health priorities in relation to the document. They are reviewing the document prior to release. The Office of Adolescent Health and Youth Development (OAHYD) provides staffing for the Council.

Data from the most recent Youth Health Survey (YHS) and Youth Risk Behavior Surveillance System (YRBSS) surveys, conducted in coordination with one another by the DPH and state Department of Education, were released. Data are used to encourage local action, and school districts may request tallies of responses from their districts. In addition, data inform DPH programs. For example, the SBHC program attended to the following results, in addition to using data from its own information system to direct its program:

- Among recent survey findings was that nutrition and physical activity have not improved in recent years. Since 2001, no significant changes have occurred in attending physical education, playing on a sports team or watching TV. According to students' self-reported height and weight, no changes have occurred in being at risk or definitely overweight. Moreover, 28% of 7th graders are at risk or definitely overweight. To address these issues, SBHC program activities have included nutrition assessment and risk reduction counseling; nutrition education via health education classes and

displays at health fairs; and assessment of physical activity, specifically sports involvement and TV/internet time. SBHCs provide sports physicals to students. SBHC clinicians measure BMI for all sports physical and well-child exams. The SBHC standards require clinicians to make a referral for elevated BMI's to a hospital or community-based nutritionist. Many SBHCs conduct annual CQI activities for healthy weight. Some SBHCs have a licensed nutritionist on site.

- Survey results also demonstrate that little change has occurred in most measures of sexual activity. Currently, 44% of high school students have had sexual intercourse; 12% have had four or more sexual partners; 61% used a condom at last intercourse; 3% have ever been diagnosed with an STD; and 5% have been or gotten someone pregnant. Unfortunately, there has been a significant drop in the percentage of youth who received HIV/AIDS education in school (94% to 89%). SBHC program standards require for the provision of a comprehensive range of reproductive health care services, including: STI and pregnancy testing; assessment of sexual behaviors and risk reduction counseling (STI prevention and birth control education to delay pregnancy); and sexual education/classroom health education on sexuality, STIs/HIV, protection methods, birth control, etc. All SBHC NPs have been trained on screening for intimate partner violence and lifetime exposure to trauma, which has been shown to increases risk of negative health outcomes, including sexual risk behaviors, sexual violence, STIs and unintended pregnancy.
- The SBHC program collaborated with the state education agency to provide a workshop for all SBHC clinical staff on motivational interviewing for behavior change. This included strategies for evoking change talk and assessing the importance and confidence associated with making behavior changes as necessitated in a risk reduction plan. Clinicians learned to use a decisional matrix to help students assess their capacity for change. Clinicians were required to complete a pre and post test to evaluate their change in knowledge as a result of this training. All clinicians received a "Adolescent Reproductive Health Education Project Curriculum " produced by Physicians for Reproductive Choice and Health. The curriculum focused on skill-building for assessing risk and student engagement in risk reduction.
- YHS data show that many students are dealing with chronic health conditions: 23% of high school students and 21% of middle school students had ever been told they had asthma; 4% of high school students and 3% of middle school students had been diagnosed with diabetes. In collaboration with school health and community providers, SBHCs provide a "continuum of care" for children with special healthcare needs, including asthma and diabetes.

Title V collaborated with Boston After School & Beyond (Boston Beyond) and Massachusetts Afterschool Partnerships re improving afterschool staffing, contributing MDPH's experience with credentialing of Early Intervention and Community Health Workers. The Title V Director also represents DPH on the Special Commission on After-School and Out-of-School Time. A report was released in FY08. Title V continues to be involved in the development of the plan to implement recommendations.

DPH significantly increased its capacity to support youth development programming in high-risk communities this year through the creation of the Prevention of Youth Violence through Promotion of Positive Youth Development community grant program in FY08. These grants fund community-based coalitions to engage in innovative, collaborative, and comprehensive youth development approaches, in the context of youth violence prevention. These approaches include mentoring programs, out-of-school time programs, employment readiness programs, conflict resolution programs, youth leadership programs, etc. (See PN #6 for details.)

Additional Activities Planned for the Coming Year (FY09):
In FY09, youth tobacco prevention activities will continue to be funded. A new youth tobacco prevention contract emphasizing youth empowerment will fund mini-grants, regional and statewide youth advisory groups, and a new component to provide education-based partnerships and technical assistance with implementing and enforcing tobacco policies in schools.

The SBHC program will collaborate with The Medical Foundation to provide trainings to clinical staff on how to develop and sustain youth programs. Trainings will address topics including: young people as resources for prevention, teaching youth to be advocates, understanding adolescent development issues, youth empowerment, and youth/adult collaboration.

The Department will enhance youth development activities through its violence prevention initiatives including violence prevention grants and new collaborations through SAPSSS (see PN #6). Coordinated adolescent health activities are also focused on mental and behavioral health including substance abuse and youth with special health care needs. The ESE, OAHYD, HIV/AIDS Bureau, Family Planning, DPH's STD Division are developing a statewide plan to increase implementation of HIV/AIDS, STD and teen pregnancy prevention in schools.

OAHYD will transition to a new director as its current director will be assuming a new position.

Priority Need #3: Improve supports for the successful transition of youth with special health needs to adulthood.

All accomplishments and activities related to this Priority Need are included under National Performance Measure #06.

Priority Need #4: Integrate service systems and data, and use data to inform practice.

Additional accomplishments and activities are noted under the following: NPMs #1, 2, 3, 8, 9, 12, 13, 14 15, 17 and 18 and SPMs # 3, 8, and 9, as well as Priorities #1, 2, 6, 7 and 10. In addition, ODT (see below) supports virtually all programs in BFHN and, through them, data is used to inform practice in relation to most National and State Performance Measures.

Additional Past Accomplishments (FY07):
The (former) Office of Data Analytics and Decision Support (ODADS) was the center of data systems, program service tracking and evaluation activity in the BFCH. ODADS staff in cooperation with DPH Information Technology Services (ITS) maintain and enhance databases to take advantage of new technology and supporting the changing needs of many of the MCH programs including the following: Early Intervention, Sexual Assault Nurse Examiner, Growth and Nutrition, EIPP, Newborn Hearing Screening, Care Coordination for Children with Special Health Needs, MASSTART, Family Planning, School-Based Health Centers, and Essential School Health.

ODADS staff participated in department-wide efforts to consolidate and upgrade data systems, and to continually update security practices. They were also actively involved in the EOHHS Virtual Gateway ESM (Enterprise Service Management) and EIM (Enterprise Invoice Management) projects. Deployment of ESM/EIM began in October 2006 for School Based Health Centers in ESM and for all cost reimbursement contracting in EIM.

The major focus of the Virtual Gateway was in expanding and developing the system to provide one state site for enrollment in any MassHealth or Health Connector insurance plan. The Data Warehouse continued to expand to include data from multiple EOHHS agencies including DPH programs within EIM/ESM.

In FY07, the SBHC program data system was changed from its legacy format using "Clinical Fusion" software to the new Enterprise Service Management (ESM) web-based application. As part of this effort, SBHC program staff worked with systems team to understand data needs, develop data collection forms, and inform the programming of the new system. Extensive training and technical assistance were provided to all 49 SBHC sites. SBHCs were required to report the following data via ESM: demographic information and insurance status of SBHC registrants; frequency of enrollments and encounters; number of registrants with services; number and type (by CPT code) of services used; number and type (by ICD-9 code) of diagnoses; and comprehensive risk and resiliency assessment data, including number of registrants assessed, screening tools used, critical health behaviors identified, and type of follow-up plans. SBHC's also reported on the final disposition of each visit (i.e., student returned to class or was sent to primary care provider, ER/hospital, or home). In FY07, 93% of visits to the SBHC resulted in students returning to class, underscoring the common goal of the SBHC and school of preserving time in learning.

The SBHC program was also the first to implement the Enterprise Invoice Management (EIM) web-based billing system. With each monthly invoice, SBHCs were required to submit information documenting non-billable services provided by medical clinicians, mental health clinicians, administrative assistants and program managers. These services included therapeutic groups, classroom health education, community health fairs, outreach (to school, community, and parents), school-wide health activities, school team meetings, clinic or agency meetings, professional development, paperwork and data entry.

WIC progressed with development of Eos, the web-based WIC system that will interface with the state Virtual Gateway initiative.

The Pregnancy to Early Life Longitudinal Linkage Database (PELL) is an ongoing cooperative project with BU School of Public Health, BFCH (in FY08—BFHN) and the CDC to create a database that follows mothers and infants longitudinally beginning at birth through early childhood. Files already linked or planned for inclusion included birth certificate, hospital discharge data, Early Intervention, birth defect, newborn screening programs, and WIC. In FY07, core linkages were updated to birth data for 2005. Many PELL accomplishments are listed under other priorities and measures. Below are additional accomplishments:

- The FY07 application to HRSA/MCHB for the Massachusetts State Systems Development Initiative (SSDI) grant focused on PELL linkage to improve HCSI #9(A) component concerning WIC-Births linkage and included calculation of IPI for SPM#3. Data about children enrolled in WIC from July 2004-December 2006 were linked to Births using all years for which birth data were available in PELL (1999-2004). Later 2005 births were added. This linkage created a longitudinal data set for children; children were born as early as 1999, and linkage allows WIC to follow them through multiple years of enrollment, potentially to age 5. In order to complete the initial child linkage, the PELL programmer first created a data set of linkable WIC records from files that WIC transmits monthly, retaining histories that are otherwise destroyed as WIC's system overwrites earlier data. The WIC files used by PELL were de-duplicated to create one record per participant. The linkage rates increased each birth year from 79% in 1999 to 94.6% in 2005. WIC files from earlier years have proportionately fewer younger children who can be linked with available birth data and younger children are easier to link--for example, they have fewer name changes--so the lower linkage rates for earlier birth years are expected. Linkage rates will improve as the linkage algorithm is refined.

During FY07, the initial linkage rates increased, for example, for 2005 to 95.8%, because the programmer added code to exclude identifiable out-of-state births.

- Analysis of EI costs and outcomes continued, with analysis of costs related to preterm birth published in Pediatrics. The PELL/EI evaluation project also presented analyses related to autism spectrum disorders at the Society for Pediatric and Perinatal Epidemiologic Research (SPER) annual meeting. Data informed ongoing discussion within EI, the DPH, and EOHHS about costs and increasing participation of children with autism. Meetings were held with the Departments of Education, Mental Retardation, and Early Care and Education concerning autism and potential linkage of PELL and special education data to better understand program outcomes and the increasing prevalence of autism. Interagency discussions to negotiate potential linkage with special education data began.
- Linked data from the birth defects registry was used to examine hospital use and associated costs for children with orofacial clefts. Information was presented at APHA.

In conjunction with the annual release of Massachusetts birth data, the MCH Epidemiologist completed and DPH regional managers distributed through their local contacts, (1) fact sheets about teen pregnancy in the Massachusetts communities with the highest teen pregnancy rates and in communities with science-based programs and (2) fact sheets and trends concerning infant mortality in communities with the highest infant mortality rates. Communities use the fact sheets to generate media attention and inform local response.

The Perinatal Periods of Risk (PPOR) analyses were updated for the state and Springfield as part the Perinatal Disparity Project activities. The overall excess feto-infant mortality for MA from 2001-2004 was 1.6/1,000 live births and fetal deaths compared to 2.0 from 1998-2002. The excess rate for black non-Hispanic went from 7.9/1,000 in the earlier analyses to 6.0. For white non-Hispanic, the excess feto-infant mortality rate went from 1.2 to 1.1/1,000. The opportunity gap between black and white has decreased, but black mothers are still 5 times more likely to experience fetal or infant death compared to white mothers. In Springfield the overall excess feto-infant mortality was 4.3/1,000 live births and fetal deaths from 1998-2002 and remained almost the same from 2001-2004 at 4.2. However, the excess rate among black and white increased from 8.5 to 10.3 and from 2.3 to 6.4 respectively. The increase in feto-infant mortality in Springfield was mainly due to maternal health/prematurity factors and maternal care among black mothers. For white mothers, the increase was mainly due to maternal health/prematurity and infants health factors.

MDPH developed a new four way partnership with BU, MA SART clinics, and CDC. The purpose of this collaboration is to improve scientific and clinical knowledge about the association between assisted reproductive technologies and pregnancy outcomes, infant health, and maternal health, with the goal of improving clinical practice, identifying possible epidemiological risks, and assisting with the development of appropriate and effective programs and policies. The collaborators published a population-based study of maternal and perinatal outcomes associated with ART in the *Maternal and Child Health Journal*.

Logic model development continued, extending for example, to the CLAS project that is implementing standards related to reducing race/ethnic disparities and the HRSA SSDI projects.

Additional Current Activities (FY08):

The newly created Office of Data Translation (ODT) provides statistics and information for needs assessment, performance management, and decision support throughout the Bureau of Family Health and Nutrition (BFHN). The MCH epidemiologist was promoted to become the ODT Director. Working closely with Bureau leaders, ODT staff conducted data analysis, evaluation, needs assessment, and surveillance activities to inform RFR development, federal grant applications, program performance

monitoring, clinical research, community mobilization and broadened public awareness. ODT analyses inform strategic initiatives to address emerging trends (e.g., gestational diabetes is increasing in MA). ODT is also actively involved with the EOHHS Virtual Gateway ESM (Enterprise Service Management) and EIM (Enterprise Invoice Management (EIM).

A complete assessment was undertaken of the Virtual Gateway and multiple components were enhanced and expanded to become more stable and able to incorporate the new systems which were moving into it. All systems were required to become ADA complaint. Public facing was developed for food stamps and is being developed for other programs. Commitment was made by the new Administration to continue to develop an integrated, comprehensive MIS system for the EOHHS. The includes a review of the Data Warehouse, which will lead to a revitalized entity to promote and enhance data sharing across agencies in accordance with federal and state privacy laws.

EI program staff, EI data managers, ODT staff, and contracted consultants, participated in ESM/EIM meetings to assist with formation of system "business rules" that assure that data entered via the client portal is user friendly for ODT staff.

Conduct requirements analysis and compare promising existing systems to select new system for birth defects and newborn hearing screening.

PRAMS completed its first year of data collection (2007 births) and, pending final weighting by CDC, appears to have successfully achieved the desired 70% response rate. After an initial unweighted response rate of 63%, staff conducted a study to assess whether increasing the reward from $5 to $10 would help assure the 70% response rate required by CDC, and then increased the reward. A PRAMS educational pamphlet was created in English and Spanish and disseminated to all local WIC offices and community health centers in the state, as well as pediatricians' offices in Boston Metro area. On February 22, 2008, staff presented preliminary PRAMS findings to the PRAMS Advisory Committee and decided on questions to include in Phase 6 MA PRAMS survey available in 2009. In June, PRAMS staff completed preliminary (internal MDPH) weighting and analyses of 2007 data to report MCH Block Grant measures earlier than projected, including for smoking during the third trimester for which it is Massachusetts' only data source.

The Massachusetts PRAMS coordinator and colleagues published *Surveillance of Births Conceived with Various Infertility Therapies in Massachusetts, January-March 2005* in Public Health Reports, March-April 2008. Based on 3 months of data from the pilot that led to Massachusetts PRAMS (2005) compared with birth certificate data, it suggests that self-reports on PRAMS may be more sensitive than birth certificates in assessing the extent of infertility therapy use among women.

The Department completed the development of draft Birth Defects regulation, which was presented to the Public Health Council in May, 2008 and taken for public hearing in late June. These regulations will codify the implementation of the amended the state law that provides for mandated reporting of birth defects (M.G.L. c.111 §67E). They will (1) require physicians to report a congenital anomaly, birth defect or birth injury to the Department within 30 days of diagnosis; (2) increase mandated reporting of a diagnosis to cover the entire prenatal period and in a child up to age three; and (3) set requirements for the use of this data for the purpose of reducing morbidity and mortality from birth defects in the Commonwealth. The proposed regulations represent the collaborative efforts of the BFHN working with an Advisory Committee established for this purpose. The Department has been working with clinicians, hospitals and professional organizations to develop regulations that are consistent with our goal to monitor patterns and trends of congenital anomalies in Massachusetts, link families with services, and assess service needs.

The Perinatal Periods of Risk (PPOR) analyses were updated for the state and Springfield as part the Perinatal Disparity Project activities. The overall excess feto-infant mortality for MA from 2001-2005 was 1.7/1,000 live births and fetal deaths, which is similar to the 1.6 rate from 2001-2004. The excess rate for black non-Hispanic of 6.0/1,000 in the earlier analyses remained the almost the same from 2001-2005 at 6.4. For white non-Hispanic, the excess feto-infant mortality rate remained stable at 1.1/1,000. The opportunity gap between black and white has decreased, but black mothers are still 5 times more likely to experience fetal or infant death compared to white mothers. In Springfield the overall excess feto-infant mortality went from 4.2/1,000 live births and fetal deaths in 2001-2004 to10.4 from 2001-2005. However, the excess rate among black and white increased from 10.3 to11.8 and from 6.4 to 16.5 respectively. The increase in feto-infant mortality in Springfield was mainly due to maternal health/prematurity factors and maternal care among black mothers. For white mothers, the increase was mainly due to maternal health/prematurity, newborn care and infant health factors. This increase among white mothers should be further explored in the coming year to determine whether this is due to yearly fluctuations.

PELL projects progressed substantially:

- PELL programmers added or updated linkages to 2005 mortality data from mothers and children, EI data, and 2003 birth defects data. MDPH geocoded the birth and death data from 1998 through 2005, and these new variables were added to PELL. The loss of the PELL programmer during grant year 2008-09 delayed the additional linkage of 2006 birth data and the creation of family groups in WIC. A new full-time PELL programmer has been hired. Most projects continued with other BU, CDC, and MDPH staffing.
- As part of continuous quality improvement efforts, PELL undertook an extensive review and revision of the core linkage algorithm, improving linkage rates for birth certificates to hospital discharge birth records from 98% to over 99%, with 98% of the records linking on the first, most stringent linkage step. Linkage of fetal death records to hospital discharge delivery records improved from 77% to 90%.
- Progress with WIC included the signing of a contract that formally provides funding from WIC to PELL and gives the programmers status as WIC consultants, easing access concerns.
- MDPH legal staff assisted in negotiating a breakthrough regarding PELL linkage to special education data to better understand EI services and outcomes related to autism. The Department of Elementary and Secondary Education (ESE, formerly the Department of Education) determined that MDPH is an educational agency for the purpose of providing EI services under the Federal Education Rights and Privacy Act (FERPA).
- A new project is the evaluation of the Early Intervention Partnership Program (EIPP), a high-risk maternal and newborn screening, assessment and service system that connects vulnerable families to basic services and health care. The purpose of the program is the early identification of maternal and infant risk and linkage to services to prevent or mitigate poor health and developmental outcomes. Recently two MassHealth Managed Care Organizations (MCOs), started to purchase EIPP services for their clients. In order to demonstrate the impact of the program and provide evidence of the benefit to program participants, BFHN ODT staff, led by the CDC MCH Epidemiology Assignee, conducted a comprehensive evaluation of EIPP. EIPP program data were analyzed to assess progress toward achieving program goals. EIPP data were linked with PELL data to conduct a population-based analysis comparing perinatal outcomes for EIPP participants with outcomes for a socio-demographically and geographically similar comparison group.
- Continued meetings between DPH, BUSPH, CDC and members of the Society of Assisted Reproductive Technology (SART) have led to the establishment of the Massachusetts Outcomes Study of Assisted Reproductive Technology (MOSART) Collaborative. The purpose of this 4-way partnership is to investigate the association between assisted reproductive technologies, birth

outcomes, and maternal and infant health, based on the linkage of core PELL data and SART's Clinical Outcomes Reporting Systems database. A memorandum of understanding has been drafted and is under legal review prior to final signing. A grant proposal to fund these innovative activities is under development. MOSART builds upon prior departmental initiatives to examine the impact of ART on reproductive health in Massachusetts.

- In addition to PELL presentations and publications reported elsewhere in this application for performance measures and other priority needs, two more manuscripts from the PELL/EI evaluation were published. Data from an additional manuscript still in review were presented to inform discussion at the at the Surgeon General's Conference on Preventing Preterm Birth in June. Presentations were given on autism spectrum disorders, hospital utilization and costs among children with craniosynostosis, and the use of longitudinal linked databases to study fetal deaths and stillbirths.
- Discussion began with DSS exploring linkage of birth and EI data to the DSS Family Net Data.

Information from EI databases too recent to be linked with births and from PELL/EI linked files informed an extensive DPH review of EI programming and costs. The most up-to-date data were used to project costs, and the linked data provided additional understanding of how referrals had changed, which children were being referred (or not) compared with the birth population, and the cost of providing services to specific groups of children.

Additional Activities Planned for the Coming Year (FY09):

Eos is projected to rollout in the fall of 2009 and EI is projected to rollout in ESM/EIM in the spring of 2009. The Virtual Gateway will continue to move more programs to public facing. DPH programs will be reviewed to see if they will benefit from public access. BFHN will continue to work with EOHHS staff in relation to the Data Warehouse as plans are developed for sharing of data.

PELL linkages will be updated and existing projects taken to next steps. The new PELL programmer will start July 15, 2008. New PELL analysts (one at BU and one at DPH) are also anticipated. Calendar Year 2006 Births (and, most likely, 2007 Births) and related data will be linked in PELL. Once the 2006 data are linked, there will be over 650,000 live birth and 3,497 fetal death records from 1998 through 2006, and 150,000 sequential deliveries in the PELL data system. Linkage of PRAMS and PELL will begin after inclusion of 2007 Births; planning will begin earlier. As PELL staff is available and WIC resources are again freed up, it will also be possible to begin WIC linkage again. We will update child linkages to 2006 births; develop, test and finalize maternal linkage for 2004, 2005, 2006 births and fetal deaths; and validate and extend WIC-Births linkage by creating WIC family groups in the PELL system. Activities to link special education data to EI/PELL data will continue. Staff will explore how linked EI/PELL data may help DPH better understand the DSS children being referred as a result of CAPTA. Other plans not described elsewhere in this application in relation to performance measures and other priorities include developing a five-year strategic plan, implementing the analytic components of new CDC Stillbirth and Downs Syndrome contract, and expanding late-preterm analyses to examine infant morbidity in the post-neonatal period, and assessing long-term morbidity and developmental delays among late-preterm infants by examining PELL-EI data.

The DPH Medical Director will lead review of the annual birth data report to examine areas of concern, significant changes and disparities. She will involve internal and external experts to identify these areas, undertake additional review and research, and develop responses.

Integrate existing and expanded birth defects surveillance into selected new system. Integrate newborn hearing into new system.

Update/begin to develop systems to better manage information for and across DPECSHN's CYSHCNs programs.

Four papers have been submitted for presentation at the MCH Epidemiology Conference in December concerning: the impact of the value of the reward on Massachusetts PRAMS, prevalence and factors associated with bullying among students with disabilities, geographic analysis of audiologic diagnostic loss to follow-up in Massachusetts, and disparities in pregnancy-associated mortality in Massachusetts, 1999-2005.

The Department will complete analysis of the comments on birth defects regulation from public hearing, make appropriate changes if indicated and present to Public Health Council for promulgation in early fall. The regulations are expected to be in place by the first of the year.

Priority Need #5: Increase capacity to promote healthy weight.

All accomplishments and activities related to this Priority Need are included under State Performance Measure #06.

Priority Need #6: Develop and implement initiatives that address violence against women, children, and youth.

Additional accomplishments and activities related to this Priority Need are included under the following National or State Performance Measures: NPMs #06 and 16 and SPM #07 (ending FY08) and SPM #11 (beginning FY08).

Additional Past Accomplishments (FY07):
MDPH support (funds and provides capacity building and technical assistance) to 17 comprehensive community based sexual assault prevention and survivor services programs (rape crisis centers) to provide the following: quality, multicultural services for adolescent and adult survivors and loved ones of survivors of all ages (24 hour hotline, individual and group counseling, accompaniment thru medical, police and court processes. Additionally, centers provide community prevention education and organizing and professional training and consultation. In state FY07, over 11,500 calls were received (11,754), close to 30,000 people received educational sessions (29,479), and over 800 people received medical accompaniments, a 47.3% increase in medical accompaniments from state FY06. MDPH also supported the statewide Spanish language sexual assault helpline and the statewide sexual assault and domestic wide coalition.

BCHAP funds statewide sexual assault capacity-building and technical assistance activities through Jane Doe, Inc., the Massachusetts Coalition against Sexual Assault and Domestic Violence. These activities include technical assistance to the rape crisis centers, as well as innovative education and training opportunities. In FY07, among other key offerings, Jane Doe provided extensive training on community engagement and primary prevention of sexual violence, featuring trainers from CDC and local experts.

Sexual assault and self-inflicted injury surveillance data is collected through the Massachusetts BRFSS and YRBS. CDC's sexual violence module continued to be utilized in FY07, and data from this module was utilized in sexual violence prevention planning by MDPH and its multidisciplinary State Prevention Team.

The most significant accomplishment associated with the Massachusetts Youth Violence Prevention Program (MYVPP) in FFY07 was the inclusion of a $2M line-item in the FY08 state budget. This funding was in many ways the culmination of a four year capacity-building process that began in 2004 with a $200,000 CDC grant. Through the $2M in state funding, the MYVPP released a Request for Responses (RFR) to allocate $1.64M in funding to high-risk communities to support youth development centered approaches to youth violence prevention.

Home visiting staff through the EIPP and FOR families programs (trained with DVSCRIP) screened for DV during home visits and provide necessary referrals and support.

Additional Current Activities (FY08):
Massachusetts added a state performance measure (SPM #11) for Shaken Baby Syndrome because of new initiatives in this area.

The Sexual Assault Prevention and Survivor Services (SAPSS) Program collaborating with the statewide coalition against sexual assault and domestic violence, provides an internal and external voice on issues of sexual assault victim service and prevention needs.

The Director of SAPSS co-chairs the Massachusetts Coalition for Sex Offender Management, along with the President of the Massachusetts Association for the Treatment of Sexual Abusers. A federal DOJ/CSOM-funded sex offender management collaborative has now merged with MCSOM, increasing its reach.

Staff participates in Jane Doe's Men's Initiative as it develops local and statewide initiatives for men to become involved in addressing men's violence against women. In FY08, Jane Doe Inc's work to increase males' engagement in this work was highly successful, culminating in a "White Ribbon Day" at the MA State House led by the current and former Governors, sports stars, survivors, high school boys, and 300 allies on site, with thousands of males across the state signing a pledge to never commit, condone or stay silent about violence against women, sexual assault and domestic violence.

Staff works within departmental initiatives and with the Massachusetts Public Health Association to explore the needs of incarcerated women in addressing violence and its health impact in their lives. Staff began working with the Department of Corrections (DOC) in FY08 on the implementation of the Prisoner Rape Elimination Act. In FY08, while continuing to support DOC's implementation of PREA through provision of training, DPH staff also convened meetings with Department of Youth Services (MA's juvenile justice agency), Jane Doe Inc., Sexual Assault Nurse Examiner Program, and local RCC providers, and helped DYS to create new PREA-related policies and materials.

The Director of Sexual Assault Prevention and Survivor Services is on the steering committee of The Massachusetts Sexual Abuse Prevention Partnership which is developing a model initiative including curricula development and local partnerships and serves as a statewide voice and educational resource on child sexual abuse prevention (see www.enoughabuse.org). In FY08, the Partnership initiated the development of a project to assist youth-serving agencies with child sexual abuse prevention policy development and implementation, based on best practices identified by a CDC expert meeting report.

VPIS staff worked with a "state funders" group to coordinate state programs addressing sexual and domestic violence. This group focused on issues of coordinated procurement, data collection and possibly coordination of provider feedback. In FY08, this group continued to coordinate efforts across

state agencies, particularly in implementing cross-agency accountability and technical assistance efforts with community-based programs struggling with compliance issues.

BCHAP oversees a statewide Sexual Assault Nurse Examiner (SANE) Program, which includes both Adolescent/Adult and Pediatric components and is operated by the Massachusetts Office for Victim Assistance. Adolescent/Adult SANE provides 24 hour/7 day a week forensic evidence collection and coordinated medical care to victims of sexual assault age twelve and over in designated hospital emergency departments across the Commonwealth. SANEs work in coordination with hospital staff, rape crisis center advocates, police and other criminal justice personnel to assure compassionate and coordinated patient care and to provide testimony should the case go to trial. Per protocol, SANE nurses provide pregnancy, STD and HIV prophylaxis for all patients seen through the program. See SPM # 7 for detailed information about Pediatric SANE Program activities.

BCHAP oversees Safe Spaces for GLBT Youth, a program designed to address suicide of and violence against GLBT youth. Safe Spaces for GLBT Youth began funding 7 providers in state FY08, 6 of which provide services to GLBT youth and one of which provides substantial technical assistance and professional development opportunities for programs around the state.

BCHAP administers Batterer Intervention Program Services (BIPS), including certification of batterer intervention programs according to the Massachusetts Guidelines and Standards for the Certification of Batterer Intervention Programs, contracting with programs to provide services for indigent batterers and monitoring programs to assure quality and compliance with standards. The Bureau continues to foster the development and enhancement of the parenting content used by batterer intervention programs to better address the mental health and safety needs of battered mothers and their children. Two programs conduct parenting after violence programs to help men be better parents.

BCHAP staff participated in the development of the Massachusetts Responsible Fatherhood Working Group, which is a network of state, community and faith-based agencies that promote services to support men as responsible fathers. The collaborative encourages nurturing and consistent fathering that supports and promotes well-being for fathers and all family members, demonstrates cooperative and egalitarian partnerships, improves outcomes for children and partners and promotes positive models of manhood.

DVIP continues ongoing work with community based providers within the RISE program to provide survivor services and community prevention and outreach in 19 immigrant/refugee communities, in 15 languages, across the Commonwealth.

The Massachusetts Rural Domestic and Sexual Violence Project works with women, children and youth in isolated and remote rural communities throughout Massachusetts. This project utilizes a specially targeted model of providing services to victims and children exposed to domestic, dating and sexual violence in rural areas. The project also provides professional and community violence prevention education in order to engage rural communities in responding effectively to these issues.

Through the Safe Families Project, the VPIS work with WIC on integrating intimate partner violence into the WIC program statewide was successfully completed in FY08. Over 25 trainings were held reaching all individual WIC programs (over 140 sites across the state) ensuring that all WIC staff were trained on how to screen and respond to intimate partner violence. In addition, it became institutionalized into the state WIC training program that all new staff are now trained on domestic violence as they begin to work for WIC.

In FY08 we continued our work with the state family planning providers, to build the knowledge-base and capacity within family planning services statewide to screen and respond to family violence.

Facilitated by the Family Violence Prevention Fund, trainings to community based family planning staff across the state (representing 12 family planning agencies and over 75 sites) will be conducted will have been conducted. Over 170 family planning counselors, clinic directors, nurse practitioners and medical assistants have been trained. In addition to the clinic staff, representatives from local referral agencies have attended each of the trainings. They have included the local regional coordinator for the Sexual Assault Nurse Examiner Program, staff from the local rape crisis centers and staff from the local domestic violence programs. Follow up technical assistance is currently underway with all of the local programs and scripts on screening are being developed for tools to be used in clinic.

DVIP continues the implementation of a new model of working with faith communities to address domestic violence and with domestic violence service providers to address the needs of survivors of faith. Three local service providers are developing capacity to work with clergy as well as with survivors of faith to address domestic and sexual violence.

Along with other state agency partners and the state domestic violence and sexual assault coalition, MDPH continued in a leadership role in the newly formed Governor's Council Addressing Sexual and Domestic Violence. MDPH staff from the Violence Prevention and Intervention Services (VPIS) unit are participating and/or providing leadership to working groups as they develop.

Domestic violence was declared a public health emergency, which will increase focus and efforts across EOHHS and Public Safety for intervention.

In FFY08, the MDPH Youth Violence Prevention Program awarded $1.64M in grants to 21 community coalitions across the state to support a broad range of youth development centered youth violence prevention initiatives. The *Prevention of Youth Violence through Promotion of Positive Youth Development* grant program recognizes the critical need to implement a youth violence prevention model that builds upon the strengths of youth by focusing on their broad developmental needs and by viewing them as key agents of change. Rather than focus solely on addressing problems and weaknesses, this program embraces an asset-based approach. This program also recognizes the need for increased multi-disciplinary collaboration across organizations and agencies serving youth.

Highlights of this Grant Program:

- This grant program provides youth in high-risk communities and neighborhoods across the Commonwealth with increased opportunities to engage in after school/out of school time activities, mentoring programs, employment readiness programs, street worker outreach, and other activities designed to strengthen the ability of young people to build a strong and lasting foundation for future success.
- The DPH is currently providing 21 community-based coalitions across the Commonwealth with a total of $1.64M to engage in youth development centered youth violence prevention programming. These programs will directly serve over 3,800 youth by June 30th, 2008.
- This grant program includes a specific focus on programming and/or initiatives provided during the hours of 2 pm and 10 pm and on weekends. There is compelling evidence of a heightened risk of violence during this time frame.

In April 2008, DPH released "Direct from the Field: A Guide to Bullying Prevention" that was distributed to all schools in the Commonwealth as well as to the media, to community providers and others. It was also made available on the DPH website.

The Suicide Prevention Program provides self-injury behavior trainings for school and residential facility staff, distinguishing this behavior from suicidal attempts, to assure appropriate interventions for each. Two

full day trainings in FY08 involved 300 participants each and one half-day training in Western Massachusetts had 100 participants.

The Massachusetts School Nurse Research Network (MASNRN) 2006 study of increasing the resiliency of youth at risk for bullying (children with special health care needs identified by the school nurse) through school-nurse-led groups that discuss webisodes related to how to handle various bullying situations had positive outcomes. The study was submitted for publication.

The SBHC program provided 2 clinical training workshops on identifying and responding to lifetime exposure to violence in school-based settings. Baseline training needs data indicated that 63% of clinicians assessed students for relationship violence and/or sexual assault. Skill-building exercises aimed at evoking sensitive information was conducted using role plays. Clinicians learned to make the connection between exposure to violence and various negative health and academic outcomes. 55% of clinicians contacted local resources as a result of the training. A second training focused on the epidemiology of youth violence and the general concepts of connection and resiliency as protective factors. The American Academy of Pediatrics "Connected Kids-Safe, Strong Secure" curriculum was presented to clinical staff along with anticipatory guidance materials for parents.

Using a retrospective cohort design with linked PELL birth and hospital data from 2001 through 2005, 1,468 women (0.9%) who had 1,675 hospital visits (emergency department, observation, and inpatient) for assault were identified and patterns of physical injury described to help inform hospital intervention plans. Results were published in a brief report "Physical injuries reported on hospital visits for assault during the pregnancy-associated period" in *Nursing Research*.

Additional Activities Planned for the Coming Year (FY09):

In FY09, the Safe Spaces program will support regional GLBT Youth Leadership Conferences for youth and adults. Providers of youth development programs will continue youth development strategies to enhance the resiliency of GLBT youth including GLBT youth within specific racial and ethnic enclaves, GLBT homeless youth and GLBT youth experiencing multiple forms of oppression.

Moving forward we hope to expand the community based youth violence prevention initiatives supported through the 21 community grants and engage a greater number of youth in a broad range of youth development programs. Associated outcomes may include, but are not limited to, the following: increased number of youth in mentoring matches, increased youth participation in out-of-school time activities, expansion of employment readiness programs, creation of more employment opportunities for youth, reduced drop-out rates, reduced rates of multiple forms of violence, and increased levels of civic engagement among youth and young adults. We will also prioritize underserved populations, such as youth with disabilities and rural youth, through additional RFR procurements released during FY09.

VPIS staff has been working internally among DPH programs on system wide screening initiatives and policy development regarding trauma informed care. Collaborating with staff of the Bureau of Substance abuse, plans are being developed to: 1) build the capacity of both batterer intervention programs and substance abuse to understand the issues that clients in each program face as well as support increased cross-referrals among programs, and 2) ensure that all funded providers are given complementary and consistent guidelines from their respective DPH programs on quality and effective services and responses to all clients.

The Sexual Assault Survivor Services (SAPSS) program will be collaborating with the newly created Executive Office of Education and in coordination with the Department of Elementary and Secondary Education, Department of Early Education and Care, and the Department of Higher Education to develop policies and

strategies to promote healthy, respectful relationships and sexuality norms and behaviors for MA youth in preschool, elementary school, middle school, high school and college. By 2011, the objective is that at least 2000 MA parents will have been exposed to at least one evidence-based or evidence-informed strategy that promotes parenting skills effective for strengthening children's relationship-level risk and protective factors for sexual violence.

Among these strategies will be culturally-specific approaches for fathers of Latino/Hispanic, African-American/Black, and Portuguese-speaking youth, which may include the MA interagency healthy fathering group developing a new focus on sexual respect and healthy parenting. Also among these strategies should be a media literacy and intersectionality strategy that will expand youth's ability to identify examples of racism, sexism classism, transphobia, and homophobia in the media as well as identify examples that challenge these negative images.

The Youth Violence Prevention Program will continue funding to 21 community-based coalitions to support activities that promote positive youth development. Activities focus on out of school time and include strategies such as mentoring, educational supports, employment supports and recreational time.

The SBHC program plans to organize regional trainings in which clinical staff will meet face to face with local resources including GLBTQI, Rape Crisis Centers, Batterer Intervention, Domestic Violence, Child Witness to Violence programs, Refugee and Immigrant Health Programs. We plan to implement a clinical training for elementary school SBHC staff on children witnessing violence and the principles of providing trauma-informed care in this population.

The SBHC program plans to invite the Neighbourhood Partnerships program of the Childrens' Hospital Psychiatry Department to share innovative approaches to violence prevention targeting elementary school children.

Priority Need #7: Increase the integration of unintentional injury prevention into relevant MCH programs.

Additional accomplishments and activities related to this Priority Need are included under the following National or State Performance Measures: NPM #10 and SPM #08.

Additional Past Accomplishments (FY07):
Quarterly injury prevention mailings were made to relevant MCH programs including WIC, Community Health Centers, EI, School Health and others.

Meetings between Injury Prevention and Control staff and staff of Physical Activity Unit to identify common goals and opportunities to collaborate began.

Injury Prevention and Control collaborated with School Health on a Child Passenger Safety campaign to distribute packet of educational materials for teachers and parents.

Injury prevention and control updates were contributed to "Growing Up Healthy" and the School Health Manual.

The brochure on safe sleep developed with MCH partners was distributed to all pediatricians in Massachusetts. The brochure was translated and produced in six languages.

Electronic dissemination of relevant child safety information (product recalls, safety alerts, etc.) to MCH partners continued.

Work continued on establishing a statewide Trauma Registry and EMS database in collaboration with the MDPH's Office of Emergency Medical Services with funding from the National Highway Safety Traffic Administration.

Information about traumatic brain injury and second impact injury was shared with 2100 school nurses through the School Health Unit's weekly e-mail distribution.

Additional Current Activities (FY08):
A plan based on recommendations from the Statewide Traumatic Brain Injury Prevention Task Force involving participants from DPH-MCH programs and external partners for primary and secondary prevention measures for traumatic brain injuries among children and youth was approved by the DPH Commissioner and released in December 2007.

Relevant MDPH public and professional education materials are reviewed to assess inclusion of injury prevention messages, correctness of messages and additional opportunities for inclusion of messages. Recommendations are made for improvement of inclusion of injury prevention in relevant MDPH materials based on the results of previous year review.

The complete build of the Statewide Trauma Registry (IT) System and piloting of the trauma and ED databases occurred. IT infrastructure has been established to enable transmission of data. In addition to providing more data on the circumstances of injuries treated in acute care hospitals, these databases will provide injury severity and outcome measures, which will be useful in evaluating the effectiveness of the disparities within the trauma system in Massachusetts.

Quarterly injury prevention mailings to relevant MCH programs continue.

Injury Prevention and Control staff and staff of Physical Activity Unit meet to identify common goals and opportunities to collaborate.

Collaborate with DSS to develop, disseminate and train DSS staff in Shaken Baby Syndrome and safe sleep.

Revise and disseminate infant/child safety checklists related to safe sleeping.

Electronic dissemination of relevant child safety information (product recalls, safety alerts, etc.) to MCH partners continues. Recalls will be included in the School Health Unit's weekly emails to 2100 school nurses.

The ESHS Evaluation Committee is piloting a reporting form to be used whenever 911 is called for the schools. Approximately 400 forms have been submitted the last three months. There are several emerging trends regarding reason for the 911 calls and the day of the week. The group plans to evaluate the data and revise the form as needed. Recommendations based on the findings will be made. Please note: the numbers of 911 calls related to mental health are being tracked.

Surveillance of unintentional injuries utilizing statewide death and hospital discharge data and dissemination of findings to DPH program staff as well as state and local audiences continued.

Using PELL data to determine intentional and unintentional injury rates for women whose pregnancy began after September 2001 and first year postpartum ended before October 2004, researchers published their findings in the article "Injury: A Major Cause of Pregnancy-Associated Morbidity in Massachusetts" in the Journal of Midwifery and Women's Health, January/February 2008. Recommendations included the importance of screening and counseling of women for domestic violence, seatbelt use, falls, and overexertion.

The Comprehensive School Health Manual contains an extensive chapter on injury prevention.

Additional Activities Planned for the Coming Year (FY09):
Review MDPH RFRs and make recommendations for inclusion of injury prevention policies, programs, and materials.

Continue to provide injury prevention quarterly mailings to relevant MCH programs ms including WIC, Community Health Centers, EI, School Health and others.

Implement recommendations from the Statewide Traumatic Brain Injury Prevention Task Force.

Begin transmission of trauma registry data.

DVIP epidemiology staff, in conjunction with the Department's Bureau of Substance Abuse Services, will begin to collect real-time emergency department data on drug overdoses, in select emergency departments around Massachusetts.

Train WIC, EIPP and FOR Families re safe sleeping and home safety checklist.

Priority Need #8: Improve oral health.

Most accomplishments and activities related to this Priority Need are included under the following National or State Performance Measures: NPM #9 and SPM #04.

Additional Past Accomplishments (FY07):
MassHealth restored dental benefits for adults. Emergency room data from years without Medicaid benefits suggested there was an increase in pregnant women using the emergency room for dental care during that time.

Additional Current Activities (FY08):
Currently, Massachusetts has 139 communities providing the health and economic benefits of fluoridation to more than 3.9 million residents. The Office of Oral Health monitors fluoridation in these communities and provides technical assistance to local boards of health and offers educational presentations to residents on the benefits of community water fluoridation.

All CHCs with contracts for the Women of Reproductive Age and Adolescents program, as a contract requirement, either have dental services on site or contracts with dental providers for services to this client base. During annual site visits to the CHCs, DPH program staff determines if the CHC is compliance.

Priority Need #9: Develop and implement public health programs, policies and collaborations that promote positive mental health.

Additional accomplishments and activities related to this Priority Need are included under NPM #16, SPM #10, and Priorities #1 and 10

Additional Past Accomplishments (FY07):
The Mental Health Commission for Children, which operated under the EOHHS, completed its work and issued a report with recommendations. Several initiatives and activities resulted from this report. The most significant is the Massachusetts Child Psychiatry Access Project (MCPAP). The Mental Health Commission for Children has since become the Clinical and Outcomes Workgroup of the Children's Behavioral Health Initiative (see FY08).

The MCPAP was funded to increase services for children with mental health issues by providing mental health teams for telephone and face-to-face consultations were pediatricians. Teams were established statewide. According to reports from pediatricians, access for immediate consultation into services improved. In addition, pediatricians were able to treat for children in the primary care site. Expansion of MCPAP to consult to School Health nurses was included in a proposed Omnibus Children's MH bill (still going through the legislative process as FY08). Expansion of MCPAP to consult to ECMH consultants was included in the YCIW ECBH Strategic Plan.

MECCS collaborated with EEC on a study of child care mental health consultants with specific focus on frequency of site visits and consultations, demographics, services provided, barriers and supports. A total of 176 behavioral/mental health specialists and 185 early education providers completed the survey. Of respondents: 32% of programs had access to one specialist while 68% have access to more than one specialist; 96% of specialists are working with preschoolers, 34% work with infants, 53% with toddlers and 42% with school-age children; 91% of mental health specialists in the early education programs responding to the survey have at least a master's degree; 67% of specialists do not bill any hours to a third party.

At the end of FY06, DPH received a 2-year grant from HRSA/MCHB to address maternal and infant mental health, including pregnant and post-partum women and infants. The Maternal and Infant Mental Health (MIMH) Project MIMH FY07 accomplishments included: 1) funding of 7 EIPP's to provide group services and additional home-visits for women experiencing or at risk for postpartum depression; 2) training to all EIPP staff and training at a statewide Summit on maternal and infant mental health; 3) contracting with an academic institution (Northeastern University) to assess state data on mental health and substance abuse for Massachusetts women giving birth or with a fetal demise in relation to infant well-being, and establish and implement an evaluation of EIPP community projects to identify best or promising practices; and 4) convening a Summit in May 2007 for 109 experts. Experts identified non-clinical community-based strategies for addressing MIMH, discussed strategies for reimbursement for MIMH, provided suggestions on research and evaluation, identified training and education strategies, made policy recommendations, and reviewed best practices for screening, assessing and clinically intervening for women and their infants experiencing mental health issues.

The Mental Health Commission for Children, which operated under the Executive Office of Health and Human Services (EOHHS) report and recommendations, completed in FY06, resulted in several initiatives and activities including the Massachusetts Child Psychiatry Access Project (MCPAP).

The state and plaintiffs submitted a plan related to a class action suit known as Rosie D that was accepted by the court in February 2007, responding to a January 2006 federal ruling in favor of the plaintiffs on behalf of children with serious emotional disturbances who were not getting community-based services that they were entitled to under Medicaid law. It was found that the state was deficient in the following areas. The Title V program is involved in the implementation of the final remedial plan.

The Massachusetts Academy of Pediatrics Children's Mental Health Task Force (CMHTF), a coalition of health care providers, health plans, state government representatives and advocacy groups provides a key venue for state agencies, advocacy groups, private provider community agencies, and professional agencies to share and solve problems. The goal is to promote access for children for medically appropriate mental health services. Key agenda items included implementation of the Rosie D Court Order and development of comprehensive mental health legislation for children.

The Massachusetts Early Childhood Comprehensive System **(**MECCS) Director participated on Rosie D Assessment Workgroup to develop a tool to determine service needs for children with serious emotional disturbance based on the Child and Adolescent Needs and Strengths tool (CANS). MECCS's efforts helped ensure that a birth to five version of the CANS tool will be included as part of the Massachusetts plan. MECCS also advised on MassHealth's selection of behavioral health screening tools for well-child visits through EPSDT, supporting selection of two tools with strong sensitivity for children birth to five.

MECCS broadened the CCHC training audience to include Mental Health Consultants (MHCs). The registration requests of MHCs outnumbered all other categories, with 21 MHCs receiving training and 14 MHCs left on waiting list.

MECCS, collaboration with United Way of Mass Bay and Merrimack Valley (UWMBMV), the Head Start State Collaboration Office (HSSCO), and TFK brought together more than 140 early childhood, mental health, and social service professionals, pediatricians, elected officials and families to discuss strategies for improving ECMH outcomes in Massachusetts. The summit included a presentation led by Dr. Jane Knitzer, NCCP, followed by a panel of state commissioners and five afternoon workshops. The proceedings and recommendations from *Young Minds Matter: A Summit to Address the Social and Emotional Wellbeing of our Youngest Children* documented by UWMBMV was recently released and 300 copies were disseminated to key leaders in Massachusetts.

MECCS supported EEC in completing a study of child care mental health consultants with specific focus on frequency of site visits and consultations, demographics, services provided, barriers and supports. A total of 176 behavioral/mental health specialists and 185 early education providers completed the survey. Of respondents: 32% of programs had access to one specialist while 68% have access to more than one specialist; 96% of specialists are working with preschoolers, 34% work with infants, 53% with toddlers and 42% with school-age children; 91% of mental health specialists in the early education programs responding to the survey have at least a master's degree; 67% of specialists do not bill any hours to a third party.

Early Intervention service providers provide a range of services to young children, including addressing mental health and emotional well-being. Specific emphasis within all early intervention services focus on parent/child attachment. Additionally, all Early Intervention providers offer assistance to parents and family members of enrolled children who may be in need of or who are seeking mental health services. In FY06, 99% of children in EI with social-emotional skill delays demonstrated improvement.

Mental health and behavioral health continue to be a priority area for SBHCs. In FY2007, there was a $300,000 earmark in the state budget for mental health and substance abuse services in SBHCs. A competitive grant application process was developed, and 5 SBHCs were selected for funding to increase

the number of students receiving screening for mental health, increase teachers' and other school staff's ability to identify and refer at risk students, and ensure coordination of SBHC mental health and substance abuse services with families and medical/mental health providers. A second competitive process was utilized to fund an evaluator of the 5 selected SBHCs enhancing mental health and substance abuse services. The evaluator monitored the work of the five sites, as well as convened a Community of Practice (CoP), a network through which SBHC staff can share expertise in mental health and/or substance abuse service delivery.

Activities related to the new funding began in April 2007 with training for approximately 60 clinicians presented by MDPH Bureau of Substance Abuse Services. Topics covered included addressing youth alcohol and other drug use through care coordination, residential services, and stabilization, addressing the needs of persons with co-occurring disorders, and resource mapping by region.

Each of the five SBHC sites that received mental health funding attended three CoP meetings in 2007 with approx 30 attendees (6 per site and including representatives from both the SBHC and the school). The key topics addressed were substance abuse screening and brief interventions, strategic chart development, community resources and partnerships. Each site was visited by the evaluators and key staff were interviewed and asked to complete a baseline survey called the Mental Health Planning and Evaluation Template (MHPET).

Initial Findings of the Mental Health Planning and Evaluation Template showed that the five targeted SBHCs: have capacity to provide integrated evidence-based services that address unique needs of each school and community; increased range and depth of MH/SA services (prevention, outreach, screening, referrals and interventions) for greater numbers of students; provided education to clinical staff, educators, students, parents and community partners that increased awareness & understanding of specific MH/SA issues; identified that engaging community and students in reducing substance abuse is major challenge; and identified service fragmentation is key issue interfering with optimal MH/SA service provision; concerns about confidentiality impede collaboration among service providers in school.

Nurses in the ESHS districts made 14,007 referrals for mental/behavioral health services. Nurses reported psychotropic medications to be the most common medications taken by students on a scheduled basis at a rate of 5.5 prescriptions per 1,000 enrolled students (asthma is most common on an as-needed basis).

The Comprehensive School Health Manual includes a chapter on mental health.

Regional Directors also promote collaborations for mental health services. All of the regional directors are working with EOHHS Planning and Review Teams (PRT) made up of staff from all regional EOHHS agency offices working with 0-22 year olds involved with 2 or more agencies. The youth usually need atypical resources that can be provided only through cost sharing. Most have experience mental health or developmental and behavioral issues, and some can no longer be cared for by their families. PRT collaborations help find solutions and resources. In addition, for example, in Boston the regional director worked with the Boston Public Health Commission's Child and Adolescent Working Group to provide mental health education and resources. In the Southeast, the regional director supported ongoing efforts in Greater New Bedford to address maternal and infant mental health issues. He assisted an interdisciplinary committee in convening a day long conference for over 75 health professionals on postpartum depression. In Central Massachusetts the regional director is a member of the Central Massachusetts Communities of Care Advisory Committee (services for youth with mental health issues and their families).

Additional Current Activities (FY08):
The Title V Director has been appointed as the Commissioner's Representative on the EOHHS Children's Behavior Health Initiative (CBHI) Executive Committee and is a member of the CBHI Implementation Coordinating team. The CBHI an interagency initiative whose mission is to strengthen, expand and integrate Massachusetts services into a comprehensive system of community-based, culturally competent behavioral health and complementary services for all children with serious emotional disturbance and other emotional and behavioral health needs, along with their families.
A key objective of this initiative is to: develop and implement integrated policies regarding early identification, access to behavioral health, assessment of behavioral health needs, service delivery and measurement of outcomes. This group will over see the implementation of the assessment component of the Court Order and begin the process to put in place an enhanced emergency response system and services for severely mentally ill children/adolescents. The MDPH MECCS Behavioral Health Strategic Plan for birth to 5 will begin to be implemented. It is expected that an enhanced data system will be developed which incorporates key data from DMH, Medicaid, DYS and DSS.

The MECCS director attended one session on the Rosie D/Children's Behavior Health Initiative and shared comments regarding a requirement that all Primary Care Providers providing well child visits to MassHealth eligible children under EPSDT administer a behavioral health screening at each visit, using one tool from a specific menu of tools.

MECCS participated in editing and disseminating EEC's final MH consultant report and in discussions about utilization of report information, particularly in continuing to support MH consultants through professional development opportunities.

The Young Children's Interagency Team (formerly MECCS Execs) co-chaired by Ron Benham and staffed by MECCS presented a strategic plan for an Early Childhood Behavioral Health System of Care to CBHI in April and is working with that group to target priorities that align with CBHI's vision. The Bureau of FHN applied as the state Title V agency for a federal SAMSHA grant, entitled Project LAUNCH, based on YCIT's strategic plan. The purpose of Project LAUNCH is to promote the wellness of young children, birth to 8 years of age. The goal is to create a shared vision for the wellness of young children that drives the development of Federal, State, and locally-based networks for the coordination of key child-serving systems and the integration of behavioral and physical health services. The expected result is for children to be thriving in safe, supportive environments and entering school ready to learn and able to succeed

MIMH activities include: 1) ongoing support groups in 7 communities, 2) statewide training involving 50-100 participants in fundamentals of maternal/infant mental health and dyadic intervention, 3) advanced training for 20-50 participants in dyadic intervention, 4) development of resource guide to be disseminated to training participants including screening tool/resources, 5)statewide maternal and infant mental health conference aimed at legislators/policy makers/providers to discuss strategies to improve identification, screening and intervention systems in MA, 6) development of Grand Rounds PowerPoint to be used by physicians at hospital Grand Rounds.

The Title V Director continues to attend CMHTF meetings regularly. The CMHTF continued to expand membership and provides a major forum for discussions of current programs, new initiatives and gaps. The focus during early FY08 was on how to implement universal behavioral screening and which tools to select. During the past several months, the focus has been on children's mental health legislation.

Comprehensive mental health legislation has been submitted to codify many of the activities being implemented under court order and extending them to all children. This legislation is currently being debated and expected to be voted on in July 2008.

MCPAP continues to expand and is seen as a major resource for pediatric primary care providers. Initial discussions have begun to explore the extension of the service to schools. Both pediatric mental health providers and pediatricians feel this program has been a real service for children and families.

Care Coordination, FOR Families, and EI Partnership programs (EIPP) screen for depression and other mental and behavioral health concerns. When needed, referrals are made to appropriate mental health services for further assessment, diagnosis and treatment. Home visitors provide women and children with information, education, and support regarding mental health issues and approaches and techniques that can promote positive mental health, including self-esteem and self-confidence, stress and anger management, and building social support systems.

The Community Resource Line fields calls regarding mental health resources for families and providers and provides referrals to agencies, treatment, and support services.

Early Intervention mental health-related services for young children and their families continue.

The Massachusetts SIDS Center provides culturally competent bereavement services statewide for families and significant others who have lost infants from SIDS, fetal demise, stillbirth, or other causes, as well as training for first responders and hospital personnel and the development and dissemination of materials. Family-focused bereavement services contribute to family preservation, prevention of child abuse and ATOD, and long-term mental health. The Center improves cultural competency among health care providers and service systems by addressing cross cultural grief responses and the development of appropriate interventions. The SIDS Center improves consistency of resources and access to services across the state by creating community-based capacity for delivering linguistically and culturally-appropriate counseling services.

The Women of Reproductive Age and Adolescents program at community health centers screens adolescents for behavioral health using the CRAFFT tool. Some older adolescents are also screened with the PHQ9. Depending on the results, the adolescent may receive a brief intervention and/or an appropriate referral.

MASNRN is conducting a FY08 pilot in three school districts to determine how many and what type of mental health assessments/interventions are included in each encounter, with a goal to expand this study if further funding becomes available.

The SBHC program staff continue to participate in the enhanced mental health/substance use services activities including regular Community of Practice meetings.

EIPP offers screening, brief intervention, support groups and refer/linkage to long-term care for depression and issues were pregnant and postpartum women.

Regional Directors continue PRT and mental health projects. For example, in the Southeast, the interdisciplinary committee followed up its 2007 conference by convening OB/GYNs and pediatricians to raise awareness about resources to screen for and assist women with postpartum depression.

Additional Activities Planned for the Coming Year (FY09):

The Title V director will continue to be the DPH representative on the EOHHS Children's Behavioral Health Initiative (CBHI) Executive Committee.

The MECCS Director will work with U Mass Center on Adoption Resources to train mental health clinicians serving MassHealth eligible children on the Child and Adolescent Needs and Strengths tool (CANS) Birth-Five. MH clinicians will be required to be certified in the use of the CANS tool for children 5-22. The CANS Birth-Five is a specialized version of the tool for young children. The Director and other MECCS advisors helped developed the Massachusetts version of the CANS Birth to Five.

If awarded ProjectLAUNCH, DPH would partner with the Boston Public Health Commission who would receive 80% of the grant funding to implement evidence-based practices such as the Nurse Family Partnership model of home visiting, as well as screening, case management and professional development.

MIMH Project funding ends 8/08. Lessons from MIMH groups may be replicated in EIPP, eventually helping to stabilize EIPP funding and activities. MIMH will continue to investigate other options to promote maternal mental health awareness, dyadic interventions, and maternal mental health screenings/reimbursement.

Pediatric Palliative Care providers will be offered training in addressing psychosocial issues for siblings of children with life-limiting illnesses.

The SBHC program plans to collaborate with the Department of Mental Health to conduct trainings for SBHC clinicians on the mental health reform Initiative including training on the approved screening instruments and their interpretation for Medicaid reimbursement. Additionally, the SBHC program has contracted with the Massachusetts General Hospital Institute of Health Professions to offer professional development opportunities for school-based Nurse Practitioners to develop competencies in pediatric mental health on core subjects including advanced mental status exam, anxiety disorders, disruptive behavior disorders, autism spectrum disorders, substance abuse, depression and psychopharmacology. The link established with MCPAP (Massachusetts Child Psychiatry Access Project) during the past year will be strengthened to ensure that all providers in SBHCs are formally enrolled as primary care providers in the MCPAP network. This will provide a heightened level of support for triage, assessment and treatment planning for students identified at risk for psychiatric problems in the primary care setting.

In the Southeast, the interdisciplinary committee plans a follow-up meeting with physicians and development of a resource directory of mental health practitioners who provide services for postpartum depression, a need identified by the local physicians in 2008.

Priority Need #10: Reduce health disparities.

Additional accomplishments and activities related to this Priority Need are included under virtually all National or State Performance Measures or Priorities, or the Measure or Priority itself is designed to address a need that represents a health or health access disparity.

Additional Past Accomplishments (FY07):
DPH contracts with local community-based providers for services and selects for high need communities and population groups. Programs also target populations of higher need. Health equity is a priority for every program and initiative. Cultural competency is seen as a fundamental component of quality services. To reduce disparities, the BFHN also works with vendors to identify and utilize evidence-based programs appropriate for the target population. Consequently, many MCH and MCH-related programs served higher

proportions of racial/ethnic minority groups than are represented in the population. These groups also tend to have higher representation in lower income communities served by public health programs. For example, in WIC for FY 07, over 56% of participants were from racial and ethnic minority groups. Nearly 40% of students in districts with ESHS contracts are reported to be racial and ethnic minorities compared to 30% in the state's entire population. The first language for more than 21% is not English compared to 15% for all state public schools; 8.6% in ESHS schools compared to 5.6% in all public schools have limited English proficiency; 39% compared to 30% are low income. EI has no income requirement for eligibility; nevertheless, 31% of children enrolled in EI in FY07 were minority, 51% below 200% poverty, and 42% enrolled in Medicaid.

BFHN (then BFCH) implemented the DPH translation procedures and guidelines, including review by the OMH of draft translations, for all translations to ensure high quality written products for linguistic minorities.

Telephonic interpreter services are available for BFHN programs.

WIC's bicultural, bilingual staff at contracted local programs reflects the population served at the site. To facilitate service access, every effort is made for participants' appointments to match staff with participants' ethnicities, cultures and languages. WIC contracts on a statewide basis with "Qwest," a telephonic interpreter service that provides translation in 150 languages for use by the local programs. In FY07, WIC distributed printed nutrition education materials in 9 languages.

The former Office of Multicultural Heath in the BFCH (now Office of Health Equity, OHE) promoted the optimal health and well being of diverse racial, ethnic and linguistic communities statewide. It served as a department wide resource to assist with managing the dynamics of differences across racial, ethnic and linguistic populations.

With the Bureau of Health Information, Statistics, and Evaluation, the OMH helped DPH and Massachusetts hospitals implement approved standards (and, for hospitals, regulations) for collection race and ethnicity data. The DPH coordinator of hospital based interpreter services provides oversight of language access in hospitals. He completed 7 reviews of interpreter services related to determination of need applications, and received reports from 95% of hospitals (100% of acute care hospitals).

To address access issues for racial and linguistic minorities, the Office of Multicultural Health's CLAS (Cultural and Linguistic Access Standards) project developed workplans for linguistic access, cultural competence, and organizational supports, and developed proposals for changes in RFR requirements to improve DPH and provider understanding and implementation of these national health care standards.

Other DPH federally funded programs in addition to Title V often include a disparities focus or specifically address disparities, and these programs support MCH efforts. Title V coordinates with them. For example, the Massachusetts Asthma Prevention and Control Program (CDC-funded) targets disparities for children ages 0-4, Blacks and Hispanics, and certain geographic regions. Interventions include reducing exposures in homes, licensed childcare centers and schools and improving disease management by using evidence-based clinical guidelines and asthma action plans. Similarly, MTCP has identified tobacco use as high among low socioeconomic groups, people with physical disabilities, and people with mental health substance abuse problems. A spring 2007 survey found that as smoking in the LGBT community was roughly twice as high as the state's overall adult smoking rate. Additional groups experience disparities in health and healthcare and have been targeted by tobacco market. MTCP focuses its efforts in communities with high smoking prevalence and significant numbers of low income and racial and ethnically diverse residents.

Additional Current Activities (FY08):
Race, ethnic and linguistic disparities were elevated to become a Departmental level priority and activities of the OMH moved to the Office of Health Equity, with the exception of translation and interpreter services, which was moved to the Departmental level Office of Communications. Title V continues to focus on disparities in its BFCH programs and to contribute to Departmental efforts, including providing funding and staff support for OHE and CLAS activities. Title V also continues to focus on disparities related to income, geographic location, sexual preference, disability and special health needs, age, insurance, etc., as they affect MCH populations.

In FY08, OHE funded 42 community-based multi-year grants across the state designed to eliminate racial and ethnic health disparities through targeted activities to build community capacity; increase health literacy; attract and retain a diverse workforce. Title V staff were involved in the selection process and ongoing contract management.

OHE distributed over 800 toolkits to support community mobilizations to eliminate health disparities. The *Critical MASS Toolkit: Taking community ACTION on health disparities* is designed to help communities and grassroots coalitions understand the different causes and impacts of disparities in health, learn where and how to look for data and patterns regarding health, and use group action as a strategy to address health disparities and related issues in communities. The OHE coordinator of hospital interpreter services completed 9 determinations of need and reviewed over 100 hospital reports.

CLAS worked with the Purchase of Service Unit to implement an Agency Self-Assessment Tool and new questions in its service procurement RFRs to better implement CLAS standards. It conducted an assessment of the internal DPH workforce and program needs and status for CLAS implementation readiness. Underway is a project to develop a guidance manual for DPH programs and contracted agencies with specific tools for CLAS implementation, an outreach project to better incorporate the community voice into CLAS, development of a training series, and initiation of an evaluation process.

DPESCHN staff participating in the Massachusetts Association of Perinatal Social Workers presented on racial disparities in birth outcomes in Massachusetts.

As part of its Roadmap initiative, the BFHN reviewed program participant demographics, including the share of minorities, low income, and publicly insured consumers compared to the Massachusetts population. As a result of this review, it was evident that the BFHN programs were serving a higher proportion of these groups than represented in the state population. A measure included on the Bureau's Balanced Scorecard continues to monitor participant demographics to assure Title V is achieving this priority.

The Department began to use screenings of the PBS series *Unnatural Causes* to increase awareness and develop responses to disparities at lunchtime seminars for DPH staff. The Central Massachusetts *Unnatural Causes* Planning Group, including the Central Massachusetts Regional Manager, also screened the series in Central Massachusetts.

All DPH staff are required to attend diversity training.

Additional Activities Planned for the Coming Year (FY09):
Ongoing and new FY08 activities will continue.

OHE will distribute an additional 600 Critical MASS Toolkits.

CLAS will complete and release the Guidance Manual, gather input from community partners to develop strategies to implement CLAS and eliminate disparities, implement a training series, release a summary report on the results of the DPH internal survey, and review/update service procurement tools and questions.

The community-based multi-year grants to eliminate racial and ethnic health disparities will enter their first full year of operation, with Title V continuing to support contract management.

All BFHN RFRs will include standard questions to assess the extent to which bidders are addressing health equity and cultural competency. Priority will be given to those who are doing well in this area.

The Children's Mental Health Initiative will include a focus on health equity and cultural competence. The Title V program will play a major role in shaping this part of the Initiative.

Regarding rural disparities, a report will be released on OB/GYN and neurosurgery accessibility in Western Massachusetts, including comparisons of Western Massachusetts and statewide birth characteristics and outcomes as well as an assessment of any shortages in the OB/GYN and neurosurgery workforce.